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Moral and legal implications of the continuity between delusional and non-delusional beliefs

Chapter:

Moral and legal implications of the continuity between delusional and non-delusional beliefs

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1 Introduction

In this chapter we explore two aspects of gradualism about mental illness by arguing that it is difficult to distinguish pathological and non-pathological beliefs on the basis of their epistemic features, and by examining and ultimately defending the claim that there is no *categorical* difference between delusional and other epistemically faulty beliefs (what we shall call *the continuity thesis*). In section 2 we argue that no effective demarcation between pathological and non-pathological beliefs can be achieved on the basis of mere epistemic criteria and we appeal to considerations about the factors that influence belief formation. This

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supports the continuity thesis. In section 3 we consider some of the moral and legal implications of the continuity thesis, focusing in particular on the role of epistemically faulty beliefs in the attribution of moral responsibility and legal accountability for criminal actions that are motivated by those beliefs.

2 Delusional and non-delusional belief

Belief is an attitude with a standard of correctness according to which true beliefs are correct and false beliefs are incorrect. We might say that it is ‘part of the “job description” of belief as a distinctive propositional attitude that beliefs are correct or incorrect depending upon the state of the world’ (Railton 1994, 74). While other cognitive states can have contents that are true or false, truth and falsehood are a ‘dimension of assessment of beliefs as opposed to many other psychological states or dispositions’ (Williams 1970, 136). Correctness conditions then follow not only from the propositional content of a state, but also from the state itself. We also evaluate beliefs with respect to epistemic values other than truth; they are appropriate targets for claims about whether they are *rational* or *justified*. Epistemic norms—including norms of evidence (‘a belief is correct if it rests upon sufficient evidence’), knowledge (‘a belief is correct if and only if it aims at knowledge’), and rationality (‘a belief is correct if and only if it is rational’)—are thought to be ones that govern belief (Engel 2007, 181). These norms govern *only* belief: it would be inappropriate to say of my imaginings or supposings that they are rational, irrational, justified, unjustified, and so on.

Many philosophers have taken such features of belief to highlight something necessary about the nature of belief and have sought to explain the conditions under which beliefs are formed and the norms to which we seem to respond in forming a belief. Some philosophers do this by appeal to belief’s having an *aim* (McHugh 2011 and 2012; Steglich-Petersen 2006 and 2009; Velleman 2000). Belief, it is suggested, is something that *aims* at the truth, such that, *as believers*, we aim to believe that *p* only if *p* is true.¹

These teleological accounts explain belief’s standard of correctness by pointing out that ‘believing *p* is correct only if *p* is true because only true beliefs achieve the aim involved with believing’ (Steglich-Petersen 2009, 395). The other epistemic norms we highlighted earlier—those of evidence, knowledge, and rationality—are explained by appeal to the claim that ‘following them promotes the aim of believing truly’ (*ibid.*, 396). If aims have rules or standards associated with achieving them,

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then epistemic norms might be considered the rules or standards conducive to achieving belief's aim (McHugh 2011, 371).

Others have claimed that belief is norm-governed, though there has been considerable debate over what the norms governing belief might be. Where normative theorists agree is on the claim that belief is constitutively normative, and it is by appeal to this that we can explain why beliefs have a standard of correctness and are governed by norms regarding their formation (see, for example, Shah 2003; Shah and Velleman 2005; Wedgwood 2002).²

The teleological and the normative accounts of belief offer explanations of our doxastic behaviours (such as focusing on the truth when we think about what to believe, gathering evidence, revising beliefs upon the presentation of new evidence, and so on). The explanations offered involve the claims that belief is constitutively aimed at truth, or constitutively normative. It is consistent with such accounts that there can be a break between truth and other epistemic features (there can be a rational false belief or a justified false belief, for example). But, even in cases in which we come to believe something false, we are guided by the aim of belief, or manifest our commitment to a norm of belief, and these aims or norms are said to be explanatory of our doxastic practice.

Delusions fail to meet many epistemic standards. It might look as if they are not beliefs aimed at truth or governed by a norm of truth, as if they are not responsive to evidence in the ways in which ordinary beliefs typically are. They might be considered as less responsive or even non-responsive to the epistemic norms outlined earlier, which we think other beliefs are responsive to. Differences between delusional and non-delusional beliefs have led some philosophers to argue that delusions are not beliefs at all, but are rather, for example, misidentified imaginings (Currie 2000) or empty speech acts (Berríos 1991).³ The *Diagnostic and Statistical Manual of Mental Disorders (DSM)-5* describes delusions as follows:

Fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g. persecutory, referential, somatic, religious, grandiose) Delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held

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despite clear or reasonable contradictory evidence regarding its veracity.

(APA 2013)

Like all definitions of delusions, the *DSM-5* definition is controversial; but, if we compare it with another influential definition, we cannot but notice that the focus is on the epistemic surface features of delusions:

A person is deluded when they have come to hold a particular belief with a degree of firmness that is both utterly unwarranted by the evidence at hand, and that jeopardises their day-to-day functioning.

(McKay, Langdon, and Coltheart 2005, 315)

Delusional beliefs are formed on the basis of insufficient evidence and may also be incompatible or badly integrated with the person's other beliefs (Bortolotti and Broome 2008, 822). This characterization of delusions as *fixed* beliefs that are *not amenable to change in the light of evidence* and as held *with a degree of firmness that is utterly unwarranted by the evidence at hand* implies that non-delusional ordinary beliefs are 'constantly modified by their experiential validation or refutation' (Maher 1988, 32) and that, in consequence, people with delusions are failing to do something that people without delusions routinely do.

Given that teleological and normative accounts of belief are seeking to explain the constraints under which people believe (that is, why they focus on evidence, why truth is their guide, and why they are responsive to norms of evidence, knowledge, and rationality in their belief formation), if delusions are not subject to such constraints, this may mark them out as different from ordinary beliefs. On the basis of their considerable epistemic faults, delusional beliefs may look different from ordinary, non-delusional beliefs in that they exhibit a difference in kind, and not just in degree. This is precisely the conclusion we seek to resist in this chapter.

2.1 Non-delusional epistemically faulty belief

Here we suggest that non-delusional beliefs are idealized in the psychological and, especially, in the philosophical literature. We do this by considering two kinds of epistemically faulty belief as they appear in the non-clinical population: beliefs from doxastic biases and beliefs from self-deception. We shall show that these beliefs also exhibit failures of rationality and depart from epistemically ideal practices of belief formation and belief maintenance.

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2.1.1. Doxastic biases

A practice is a *doxastic bias* if it is an unreliable doxastic practice in terms of truth (Hazlett 2013, 41). The self-enhancement bias is one example of a widespread doxastic bias, and this encompasses ‘overly positive self-evaluation, unrealistic optimism, illusions of control, self-serving causal attributions, valence biases in recall and processing speeds, biased attention to evidence, [and] biased self-focused attention’ (ibid., 52). In an oft-cited study that looked into the self-perceptions of people with and without depression, participants’ self-ratings across various dimensions were compared with ratings given by other people about those same participants. It was found that the ‘initial self-perceptions of the depressed subjects were less discrepant with observer ratings’ than were those of controls (Lewinsohn et al. 1980, 210). The self-ratings of people with depression ‘did not differ significantly’ from those of their observers, whereas controls rated themselves ‘significantly more positively’ than did their observers. People with depression, then, were the ‘most realistic’ with regard to their self-perceptions, whereas controls ‘were engaged in self-enhancing distortions’ (ibid., 211).

Several other studies have shown that most people are vulnerable to positive illusions, considering themselves (and sometimes their romantic partners) to be above average, or better than most others, when asked about positive traits and abilities. Moreover, people tend to exhibit unrealistic optimism about their future, underestimating the likelihood of their experiencing negative events and overestimating the likelihood of their experiencing positive events (for a review, see Hazlett 2013 and Bortolotti and Antrobus 2015). In the psychological literature, it has been suggested that positive illusions and unrealistic optimism are adaptive and contribute to mental health, making people happier, more productive and creative, more caring, and more resilient (Taylor 1989; Sharot 2011). In his discussion of the empirical studies, Peter Railton claims that ‘[i]t would appear to be part of the normal, healthy operation of one’s self image that one discount negative evidence and defy the odds’ (Railton 1994, 93).

The biases discussed here serve to modify the standards for sufficient evidence required for belief. People do not treat evidence the way they do on purely epistemic grounds; non-epistemic factors are involved when they form beliefs about themselves or make predictions about their future.

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2.1.2. Self-deception

In self-deception, beliefs include a motivational element that can involve a process of misreading or ignoring evidence as one comes to a belief. The motivational element of the belief-forming process may be a pro-attitude towards a proposition's being *true* (wishful self-deception), a proposition's being *believed* (willful self-deception), or a proposition's being *false* (dreadful self-deception; see Van Leeuwen 2007, 423–5).

Let us give an example to demonstrate the non-epistemic factors involved in self-deceptive belief formation. Consider a person who has the false and motivated belief that his wife is faithful. There may be evidence available to him that his wife is unfaithful, insofar as certain features of her behaviour are *perceptually available* to him (he sees that she arrives home late, that she is uninterested in him, and so on). We might think, though, that the alternative, epistemically more worthy belief that his wife is unfaithful is unavailable in a weaker sense: it has a kind of *motivational unavailability*. The person, we can presume, is highly motivated for it to be the case that his wife is faithful (wishful self-deception), or at least is motivated for it to be the case that he *believes* that his wife is faithful (willful self-deception). Consider another case: that of a person with anorexia nervosa who comes to believe that she is overweight, and she has a strong desire for this to be false (dreadful self-deception). Is the person in these cases aiming at the truth when she forms the belief (as the teleological account of belief would claim)? Or is she responding to a norm of belief (as the normative account of belief would claim)? It might be that she is doing either, but what makes it the case that these beliefs are aimed at the truth or governed by a norm of truth may be very different from what is going on in an epistemically ideal case, where motivational factors are not playing a significant role in the fixation of belief.

2.2 Non-epistemic factors in faulty belief

We outlined common instances of beliefs that fail to satisfy the same standards that delusions, too, fail to satisfy. Either the mechanisms responsible for belief production are not geared in all cases towards truth or, even when they are, they often miss that target. The cases of belief we have discussed above depart considerably from the idealized conception of beliefs as mental states that are responsive to evidence and revised in the light of counterevidence. The formation and maintenance of the beliefs we considered are paradigmatically influenced by non-epistemic factors.

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To further explain what these cases have in common and how they can be regarded as instances of epistemically faulty belief, we can look at Yaacov Trope and Akiva Liberman's (1996) concept of *confidence thresholds* for belief. The idea here is that there is a correlation between a person's confidence threshold and the evidence that is required to reach the threshold: the lower the threshold, the less evidence is required to reach it. The *acceptance threshold* is 'the minimum confidence in the truth of a hypothesis that [one] requires before accepting it, rather than continuing to test it', while the *rejection threshold* is 'the minimum confidence in the untruth of a hypothesis that [one] requires before rejecting it and discontinuing the test' (Trope and Liberman 1996, 253, cited in Mele 2000, 34). What is meant by *cost of information* in this model is the resources and effort a person needs in order to acquire and process information relevant to the target proposition. What is meant by *cost of false acceptance* and *cost of false rejection* is the subjective importance a person attaches to avoiding falsely believing a proposition, and falsely believing the negation of a proposition, respectively (Trope and Liberman 1996, 252, cited in Mele 2000, 34). If this model is correct, our desires can influence our beliefs by functioning to change our confidence thresholds: (1) in several cases of doxastic bias, pro-attitudes play a role in belief formation; (2) in the case of self-deception, an attitude towards the target proposition plays a role in generating a belief in that proposition, a belief that would not be acquired were the attitude absent. So belief formation is often influenced by non-epistemic factors, which include motivational ones.⁴

Allan Hazlett suggests that there may be coping mechanisms in the form of self-deception, which would go some way towards offsetting the negative consequences of bad life events, and that such mechanisms may also give rise to 'less extreme' biases that could be 'useful as means of coping with the events of everyday life' (Hazlett 2013, 61). Ryan McKay and Daniel Dennett (2009) go as far as to argue for the presence of a doxastic shear pin, a mechanism that allows desires to influence belief formation when the person would be harmed by believing what she has evidence for and would struggle to manage negative emotions. In some of these cases, the epistemically faulty belief (they call it 'misbelief') can be biologically or psychologically adaptive. Interestingly, candidates for adaptive misbeliefs include positive illusions and delusions.

We saw that in many cases non-epistemic factors influence the fixation of belief, and this indicates that a different strength of regulation for truth, or responsiveness to evidence, and so on applies to different instances of believing. Hence it is difficult to group all beliefs together by appealing to their epistemic surface features. To be clear: we are not suggesting that

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the attitudes resulting from doxastic biases and self-deception are not beliefs; we think that they are. Rather our claim is that it is implausible to suggest that the reason why these cognitions are beliefs is that they share some good epistemic feature with other, non-delusional beliefs and then claim that delusional beliefs are different in kind because they are epistemically poor or lack some good epistemic feature.

Next we turn to delusions and argue that the way in which they are formed is continuous with the epistemic faults detected in the two cases discussed above, namely doxastic biases and self-deception.

2.3 Delusional belief

Let us turn now to epistemically faulty beliefs that are also delusional. In this section we shall argue for the continuity thesis in two steps. First, we notice how the most popular theories of delusion formation are compatible with, or actively support, the continuity thesis. Second, we observe that the epistemic faults that characterize delusional beliefs also characterize non-delusional beliefs, and in particular beliefs due to doxastic biases or self-deception.

2.3.1. Delusion formation

Here we cannot provide a detailed description of all the promising theories of delusion formation discussed in the literature, but by appealing to the most influential proposals we aim to show that delusions are best understood as beliefs, and as continuous with non-delusional beliefs. In particular, delusions are seen as understandable (sometimes even rational) responses to anomalous experience. The process by which people form delusions should not be understood as radically or categorically different from the process by which people form ordinary beliefs.

According to the one-factor account of delusion formation, people with delusions do not suffer from an *abnormal* deficit or bias in their mechanisms of belief formation or belief evaluation. The clinically significant difference between a person with delusions and a person without is in the kinds of experiences they have. Brendan Maher claimed that 'delusional beliefs are developed in much the same way that normal beliefs are' (Maher 1988, 22) and that the experiences of people with delusions are such as to distort the evidence available to them. This means that delusions are not held in the face of obvious counterevidence, as they are often characterized; rather they are held 'because of evidence strong enough to support [them]' (Maher 1974, 99). One-factor accounts do not deny that reasoning biases might be involved in the process by which people come to form delusional beliefs; they claim only that

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'delusions occur when those biases are exaggerated or introduced by intractable anomalous experiences ... the delusion results from an anomalous experience rationalized by a mind whose divergence from ideal rationality is within the normal range of human psychology' (Gerrans 2002, 52).

One popular version of the one-factor theory is the prediction error theory proposed by Phil Corlett and colleagues.⁵ When people experience something that does not match their current understanding of the world, a prediction error signal is produced and either the input is reinterpreted or the model of the world is revised to take into account the new experience. The hypothesis is that, in people with delusions, the excessive production of prediction error signals falsely suggests that a person's internal model of the world needs to be updated.

Prediction error theories of delusion formation suggest that under the influence of inappropriate prediction error signal, possibly as a consequence of dopamine dysregulation, events that are insignificant and merely coincident seem to demand attention, feel important and relate to each other in meaningful ways. Delusions ultimately arise as a means of explaining these odd experiences.

(Corlett et al. 2009, 1)

On this account, delusion formation differs from the formation of other beliefs only in so far as prediction error signalling is disrupted. The process of belief formation is the same in the case of delusional and non-delusional beliefs, but the signalling is disrupted in the case of delusions.

According to the two-factor account of delusion formation, we need to appeal to two factors in order to explain why a person comes to form a delusional belief. The first factor is the anomalous experience appealed to by one-factor theorists, but two-factor theorists claim that this is not sufficient for the delusion to be formed or maintained, and so some clinically significant deficit or bias in belief-forming or maintaining mechanisms also needs to be posited. Philosophers and psychologists endorsing this view disagree on how to characterize the second factor. Some characterizations of the second factor provided so far indicate a difference in degree rather than in kind between delusional and non-delusional beliefs. According to the version of the two-factor theory recently proposed by Max Coltheart and colleagues, people with delusions form beliefs in line with a Bayesian model of abductive inference, according to which 'one hypothesis H_1 explains observations O better than another hypothesis H_2 just in case $P(O|H_1) > P(O|H_2)$ ' (Coltheart, Menzies, and Sutton 2010, 271, cf. McKay 2012).

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Considering a case of the Capgras delusion⁶ where a man mistakes his wife for an impostor, the two hypotheses in play are the *stranger hypothesis* (the woman who looks like my wife is not my wife) and the *wife hypothesis* (the woman who looks like my wife is my wife). Coltheart and colleagues argue that

the observed data are clearly much more likely under the stranger hypothesis than under the wife hypothesis. It would be highly improbable for the person to have the low autonomic response if the person really was his wife, but very probable indeed if the person were a stranger. (Coltheart, Menzies, and Sutton 2010, 277)

[I]f the stranger hypothesis explains the observed data much better than the wife hypothesis, the fact that the stranger hypothesis has a lower prior probability than the wife hypothesis can be offset in the calculation of posterior probabilities. And indeed it seems reasonable to suppose that this is precisely the situation with the subject suffering from Capgras delusion. The delusional hypothesis provides a much more convincing explanation of the highly unusual data than the non-delusional hypothesis; and this fact swamps the general implausibility of the delusional hypothesis. (Ibid., 278)

On this view, the second factor explains the maintenance of the delusion. The person does not reject the delusional hypothesis once the disconfirming data start to come in, because he seems to be

ignoring or disregarding any new evidence that cannot be explained by the stranger hypothesis. It is as though he is so convinced of the truth of the stranger hypothesis by its explanatory power that his conviction makes him either disregard or reject all evidence that is inconsistent with the hypothesis, or at least cannot be explained by the hypothesis. (Ibid., 279–80)

The account of delusion formation proposed by Philippa Garety and David Hemsley (1994) explicitly endorses the continuity thesis. The basic thought is that delusions are formed due to a multiplicity of factors, including past experience, affect, self-esteem, motivation, and biases in reasoning (especially probabilistic reasoning) and perception. Some factors interact with one another, and some are more prominent in the formation of some delusions than others. There is no need to hypothesize a radical deviation from normal processes of belief formation and maintenance; some of the biases responsible for the epistemic faults of delusions—such as selective attention, confirmation bias, and jumping to conclusions—may affect people with delusions more than clinical and

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non-clinical controls, but they are not distinctive factors. The multifactorial view acknowledges that many of the biases responsible for the formation of delusional beliefs are biases that all people are prone to. This view explicitly characterizes the difference between delusional and non-delusional beliefs as a difference in degree.

2.3.2. Delusions and other epistemically faulty beliefs

Beliefs formed as a result of doxastic biases are continuous with delusional beliefs, as their epistemic faults can be described in terms of the subject's failing to take into account or respond to statistical evidence that is available to them. It has been claimed that in some cases, people who develop delusional beliefs have the same biases as the rest of the population, but are vulnerable to those biases to a greater extent. For instance, delusional and non-delusional beliefs can be due to the *attribution error*, whereby the person attributes positive events to herself and negative events to external factors or to other people. People who develop persecutory delusions may have an exaggerated tendency to fall prey to the attribution error and other similar biases (Freeman et al. 2002). In other cases, people who develop delusional beliefs have a different bias from the one that affects the rest of the population, but both groups are affected by biases that lead to the formation of epistemically faulty beliefs. For instance, when evaluating evidence for a statement, people tend to wait until they have more clues than they need before coming to a decision. This tendency is often called 'conservatism' (Stone and Young 1997; McKay 2012). Empirical evidence, it has been claimed, suggests that people who develop delusions have the opposite tendency and 'jump to conclusions', that is, come to a decision about whether a statement is true without having sufficient evidence (see Fine et al. 2007, but also Ross et al. 2015). This latter tendency is often called 'revisionism'. Both tendencies are epistemically problematic, but conservatism is more widespread in the non-clinical population.

Even the epistemic feature of delusions that is considered most distinctive—resistance to counterevidence—is actually a very common feature of non-delusional beliefs (Bortolotti 2009, ch. 2). Once they adopt a hypothesis, people are very reluctant to abandon it, even when copious and robust evidence against it becomes available. This is true of prejudiced and superstitious beliefs (see, for example, Rusche and Brewster 2008), but also of beliefs in scientific theories (see, for example, Chinn and Brewer 2001), a context in which responsiveness to evidence should be seen as highly important. Self-enhancing beliefs are especially resistant to counterevidence, and people continue to believe that they are skilled, talented, attractive, successful, and so on even when their life experiences repeatedly suggest otherwise. In order to maintain a positive

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image of themselves, they reinterpret negative feedback and focus on selected evidence that supports their self-enhancing beliefs (Hepper and Sedikides 2012).

Beliefs in the context of self-deception can be vulnerable to a number of doxastic biases and are also resistant to counterevidence. Indeed, non-clinical instances of self-deception have been compared to *motivated* delusions—that is, delusions that can be construed as playing a defensive function and delusions whose formation is affected by what the person desires to be true (McKay and Kinsbourne 2010). Motivated delusions can include erotomania, where a person believes that another is in love with her; grandiose delusions, where the person believes that she is, for example, a largely misunderstood genius; and anosognosia, where the person denies having a serious impairment.⁷ In the formation of such delusions, just like in self-deception, motivational influences play a role in the adoption of a belief, and the resulting belief is not well supported by or responsive to the evidence.

These considerations are, obviously, not conclusive. We have considered how delusional and non-delusional beliefs are formed and what epistemic faults delusional and non-delusional beliefs are vulnerable to. We might look elsewhere for the difference between delusions and otherwise epistemically faulty beliefs. Considering how a person reacts when she is made aware of her cognitive biases and confronted with powerful arguments against her belief might introduce a significant difference between delusional and non-delusional beliefs. We might think that a person with delusional beliefs would reject alternative explanations of her beliefs or experiences offhand, whereas a person with non-delusional beliefs would be much more responsive to feedback.

As it happens, empirical evidence does not support discontinuity in this area. It is well known that people are very resistant to changing their beliefs, even when they are told what reasoning mistakes and biases affected the formation of those beliefs (Stalmeier, Wakker, and Bezembinder 1997; Lichtenstein and Slovic 1971; Tversky and Kahneman 1983), and we already saw that people ignore or reinterpret negative feedback on their own performance in order to protect self-enhancing beliefs. The claim that people with delusions are resistant to cognitive probing also needs to be qualified. There are strong indications that cognitive behavioural therapy is efficacious in reducing the rigidity of delusional states and the person's preoccupation with the topic of the delusion (Coltheart 2005; Kingdon, Ashcroft, and Turkington 2008). Although the evidence gathered so far does not suggest that cognitive behavioural therapy is effective in leading the person to abandon a delusion altogether, cognitive probing does contribute to the person's

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adoption of a more critical attitude towards the content of the delusion (Bortolotti 2009, ch. 2). Thus focusing on how people respond to challenges is not a promising way to argue for discontinuity between delusional and non-delusional beliefs.

2.4 Interim conclusion

So far we have argued that epistemically faulty delusional and non-delusional beliefs do not differ in kind. Delusions, like other beliefs, are resistant to counterevidence, and the formation of delusions, like the formation of other epistemically faulty beliefs, is influenced by non-epistemic factors. In the case of delusional and non-delusional beliefs alike, there can be considerable resistance to abandoning a belief once it has been adopted and biases and motivational factors may influence belief formation. Next we move to the moral and legal implications of this view.

3 Moral and legal implications of the continuity view

What factors should be taken into account when attributing criminal responsibility to perpetrators of severe crimes? Here we will discuss three cases of people with epistemically faulty beliefs who committed serious offences. Our purpose is to ask whether the presence of *delusional* as opposed to *non-delusional* beliefs is always a reason to doubt the responsibility people have for those actions that seem to be guided or motivated by their beliefs. If there is no categorical difference between delusions and other epistemically faulty beliefs, why is the presence of delusions regarded as a key factor in establishing criminal responsibility?

The first case we consider is that of Bill, who attacks a neighbour because he believes the neighbour is shouting insults at him and intends to harm him (Broome, Bortolotti, and Mameli 2010). The second case is that of Jeremiah Wright, who killed his son while believing that his son was a cardiopulmonary resuscitation (CPR) dummy (Kotz 2011). The third case is Anders Breivik's perpetration of mass murder in Norway (Bortolotti, Broome, and Mameli 2014).

The analysis of these cases puts some pressure on the view that the presence of delusions is sufficient to determine whether agents are morally responsible and legally accountable for their criminal actions.

3.1 Three cases

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3.1.1. Bill

Matthew Broome and colleagues describe the case of a young man with a diagnosis of schizophrenia who attacked his neighbour after experiencing auditory hallucinations about that neighbour's making loud noise and insulting him repeatedly. Bill was convicted of assault but his sentence was affected by a pre-existing diagnosis of schizophrenia. He was sentenced to two years' probation and his custodial sentence was suspended.

[S] uppose Bill had actually had a very noisy neighbor. What kind of ascription of responsibility would we have made in relation to the harm inflicted on his neighbor in those circumstances? What kind of punishment would Bill have deserved for his attacking his truly noisy neighbor? Should the fact that the experiences were hallucinatory (and thereby that the neighbor was not in fact noisy) make a difference in relation to how we conceive of Bill's responsibility for what he did and of the punishment he deserves? It is true that Bill was hallucinating: He was hallucinating that his neighbor was making loud noises, and the content of the hallucination explains in part why he attacked his neighbor. Had he not hallucinated that his neighbor was making loud noises, Bill would have probably not attacked and harmed his neighbor. But it is also true that having noisy neighbors does not morally justify assaulting them. That is, had Bill's neighbor been truly noisy, Bill would have still been doing something blameable in assaulting his neighbor. If one has a noisy neighbor, then one should try to convince his neighbor to be less noisy, and, failing that, one should perhaps call the police.

(Broome, Bortolotti, and Mameli 2010, 182)

We find here that the psychotic symptoms experienced by Bill help to *explain* but not necessarily *justify* his aggressive behaviour towards his neighbour. His experiences (auditory hallucinations) and delusional beliefs (the belief that his neighbour intended to harm him) help to explain why he assaulted his neighbour, but the assault was not inescapable or excusable on the grounds provided by such experiences and beliefs.

What we can draw from the case of Bill is that the presence of delusions is not sufficient for us to regard the person who committed a crime as unaccountable by reason of insanity, though of course the presence of delusions is relevant to the person's full psychological profile at the time when the crime was committed and thus should be taken into account.

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For instance, it is possible that the presence of the delusion signals the presence of reasoning impairments that affect the agent's decision-making capacities.

3.1.2. Jeremiah Wright

Our next case is different from the case of Bill in important ways. On 14 August 2011 Jeremiah Wright killed his seven-year-old son, Jori, who had cerebral palsy requiring full-time care (Kotz 2011). He beheaded and dismembered the child in the home he shared with the child's mother. Wright was charged with, and tried for, first-degree murder. Wright was suffering from a delusion at the time of the killing (as well as before and after the act). He believed that Jori was not his son, but a CPR dummy placed in his home as part of a government experiment. Wright was found not guilty on the grounds of insanity.

A police report stated that 'Wright said that he recently saw the way the dummy looked at him and there were signs and little things the dummy did to him that let him know that Jori was not his son, but a dummy' (Quigley 2013). Dr. Sarah DeLand, director at the mental facility in which Wright was housed, and George Seiden, a psychiatrist working with Wright, testified that Wright believed Jori was a CPR dummy. Wright told DeLand and Seiden that Jori was a government social experiment, claiming: 'I don't believe they can do anything to me because it wasn't a real person. His skull was made of plastic. He had foam in him' (ibid.).

Now let us suppose, as we did with the case of Bill, that Wright's beliefs were not delusional and their contents were true. Let us suppose, then, that Jori, the seven-year-old boy, was actually a CPR dummy. What ascription of responsibility would we make with respect to the 'harm' inflicted on Jori, and what kind of punishment would Wright deserve? In Bill's case, his belief that his neighbour was shouting at him would help to explain, but not to justify Bill's assault, as having noisy neighbours does not justify assaulting them. But if Wright had a CPR dummy in his home, then it would not be morally wrong to 'decapitate' and 'dismember' that dummy, given that it would not be a living being capable of feeling pain and suffering.

Wright's psychotic symptoms, like Bill's, help explain his behaviour. Bill feels threatened and frustrated because he believes his neighbour is causing him trouble and might intend to harm him. In addition, Bill might think that other courses of action are closed to him, given his history of mental illness—calling the police, for instance, may not be an attractive option if Bill suspects that the police will not believe him. Wright wants to prevent the government from spying on him, and thus wants to destroy

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the dummy. The difference between the two cases is that, in Wright's case, if the content of his belief were true, it would not be morally problematic to destroy the dummy, and the action could be justified by Wright's desire to stop the government's intrusion in his life. Wright's actions would be permitted, given his belief that Jori was a CPR dummy. Unlike in Bill's case, then, in Wright's case the presence of the belief is sufficient for us to regard the person who committed the crime as unaccountable, since what Wright did would not be morally problematic if his belief were true. Wright's actions were not *inescapable*: he could have done otherwise, given his beliefs. But his delusions offer both some explanation and justification for his actions.

From the first two cases alone it is obvious that the relationship between delusions and criminal responsibility is not a straightforward one. In Bill's case, the delusion went some way towards explaining his action, but it did not justify that action. In Wright's case, the delusion went some way towards explaining and justifying his action, as it relieved him of culpability. However, his action was not *inescapable*, given his delusional beliefs.

3.1.3. Anders Breivik

In July 2011 Anders Breivik killed 77 people in Norway. In August 2012 he was sentenced to 21 years in prison. As part of his first psychiatric evaluation, he was diagnosed with paranoid schizophrenia and some of his more implausible beliefs were regarded as persistent, systematized, and bizarre delusions. For instance, one belief he reported was that he was the leader of a Knights Templar organization that, according to the Norwegian police, does not exist. However, this first assessment that led to the diagnosis of schizophrenia was overruled by a second assessment, according to which Breivik's strange beliefs were not psychotic symptoms in the context of schizophrenia or of some other psychotic disorder, but could be explained by a personality disorder. On the basis of the fact that he never manifested hallucinations, the second pair of assessors described Breivik's behaviour as caused by a narcissistic personality disorder accompanied by pathological lying (Melle 2013).

If it had been shown that Breivik experienced psychotic symptoms at the time of his crime, then he would have faced trial with a diagnosis of psychosis and would not have been regarded as accountable for his actions. This is because, in the Norwegian Criminal Procedure Code, when one has psychotic symptoms, one cannot be attributed criminal responsibility for his or her action: 'a person is not criminally accountable if psychotic, unconscious, or severely mentally retarded at the time of the crime' (Melle 2013, 17). If Breivik's diagnosis of a psychotic disorder had

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been confirmed, he would have been regarded as 'criminally insane' and sentenced to compulsory psychiatric treatment (Måseide 2012). As a result of the second assessment and his new diagnosis of personality disorder, Breivik was held accountable for his actions, as he was thought not to have been psychotic at the time of his criminal act.

Some questions could be raised about the relation of Breivik's beliefs to his actions. Just as Bill could have attempted to talk to his neighbour or call the police instead of planning an assault and just as Wright could have removed the 'dummy' from his home or put it out of sight without destroying it, so too could Breivik have genuinely believed that multiculturalism was one of the greatest harms in Norwegian society without engaging in the actions that led him to kill 77 people. Breivik's thoughts could have been channelled into joining a political party in which such views were shared, or he could have campaigned against multiculturalism. That is, his beliefs go some way towards explaining his action but do not justify it and do not make it inescapable.

3.2 Does it matter whether the perpetrator's beliefs are delusional?

The cases we have looked at highlight that we cannot assume that the presence of delusions implies no or reduced responsibility for action. A more local and nuanced view of responsibility needs to be articulated. More precisely, further argument is needed to support the claim that the presence of delusions and other psychotic symptoms is an appropriate criterion for criminal insanity.

In all three of the cases we considered (each coming from a different legal jurisdiction: the United Kingdom, the United States, and Norway), one key question in the psychiatric assessment that led to sentencing was whether the person's system of beliefs was delusional. We saw that the presence of a diagnosis of schizophrenia was instrumental to Bill's lenient sentence. We saw that Wright was found not guilty for reasons of insanity and was committed to a psychiatric hospital for care. And we saw that the presence of delusions alone, if confirmed by the second psychiatric assessment, would have indicated Breivik's lack of responsibility for his mass murder in Norwegian law.

The continuity thesis we have defended in section 2 makes it problematic to rely so heavily on the presence of beliefs that are delusional when assessing responsibility. For claims about responsibility, the significance of the presence of delusional beliefs may derive from the following consideration. If poor reality testing (or some other relevant cognitive deficit associated with delusion formation) is affecting the beliefs a

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person is prepared to endorse to the extent that such beliefs are implausible even to members of the person's culture or subculture, then maybe such failure of reality testing (or other relevant cognitive deficit) is also implicated in some of the person's decision-making processes, including those processes that led the person to act criminally. But this link between the presence of psychotic symptoms and impaired decision-making is just a hypothesis that needs to be tested.

The assumption that people who have psychotic symptoms or who have received a diagnosis of schizophrenia lack responsibility or have reduced responsibility for their actions on the grounds that their decision-making capacities are impaired is especially problematic, because the behaviour of two people with psychosis or schizophrenia can differ almost entirely. Some people with schizophrenia are able to function well, both cognitively and socially, and to control their delusions to some extent. The presence of psychiatric symptoms and of a diagnosis of schizophrenia should be taken into account in the courtroom, but it should not be regarded as sufficient for determining responsibility.

4 Conclusions and implications

In section 2 we defended gradualism with respect to the distinction between delusional and non-delusional epistemically faulty beliefs. We argued that there is continuity between them: they can be resistant to counterevidence and their formation process may be influenced by biases and motivational factors. Reflecting on the recent psychological literature on delusions, we saw that the mechanisms posited to explain the adoption of delusional hypotheses are not radically different from, but are continuous with, standard mechanisms of belief formation.

In section 3 we turned to the implications of the continuity thesis for moral and legal issues concerning responsibility for action. How should we view the presence of delusions, which is often considered as a key criterion for criminal insanity, if there is no clear demarcation between delusional and non-delusional beliefs to be made on epistemic grounds? We argued that the role of delusional beliefs in motivating action does not seem to be different from the role of other epistemically faulty non-delusional beliefs, unless we assume that the presence of delusions also signals the presence of a cognitive deficit that impacts on the decision to commit a given crime.

Moreover, we suggested that having beliefs that are epistemically faulty, whether delusional or not, rarely provides a justification for criminal action. It may contribute to an explanation of the crime, but in most cases it does not make the criminal action inescapable or excusable.

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Notes:

1 At least one other aim of belief has been put forward by Conor McHugh: the aim of knowledge (McHugh 2011). It is beyond the scope of this chapter to discuss the various formulations of the aim account; we only mention it here to make salient the idea that ordinary beliefs are idealized in certain respects. This omission is also acceptable since, as Timothy Chan has pointed out, '[g]iven that knowledge entails truth, if belief aims at knowledge, it also aims at truth' (Chan 2013, 10).

2 These are not views that all of the present authors endorse, but they do demonstrate how we might think about non-delusional beliefs, their link with truth, and the conditions under which they are formed (see Sullivan-Bissett under review; and Sullivan-Bissett and Noordhof under review, for objections to these accounts).

3 We will assume a doxastic approach to delusions in this chapter (for a defence of doxasticism, see Bayne and Pacherie 2005 and Bortolotti 2009, 2012).

4 It might be that it is even justified to make justification standards and confidence thresholds context-relative. This kind of claim is not the one we are after in this chapter. We are not trying to give a normative account of how believers ought to behave; rather we are doing descriptive work. So we remain neutral on whether it is justified or rational to have lower evidence thresholds in some cases. We are just pointing out that, as a matter of fact, we *do* have lower thresholds.

5 For another account of delusion formation based on a prediction error model, see Hohwy (2013).

6 Capgras delusion is the '[b]elief that others, often related, have been replaced by identical or near identical others; variations exist in which objects or animals are believed changed; the symptoms may be chronic or permanent' (Ellis, Luat , and Retterst l 1994, 119).

7 See Mele (2008), Davies (2008), and Bortolotti and Mameli (2012) for a discussion of how delusions relate to self-deception.

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